**Purpose and instructions:** This checklist is to be completed by the sending site and shared with the receiving site, in order to ensure safe preparation of each patient/client/resident for evacuation or repatriation. Please **create three (3) copies**: one stays with the sending site, one goes into the patient/client/resident’s medical chart, and one is for the transport lead/escort to be given to receiving site.

|  |
| --- |
| **Administrative information** |
| **Patient Name** |  | **Personal Health Number (PHN)** |  |
| **Name of emergency contact or next of kin** |  | **Phone # of emergency contact or next of kin** |  |
| **Prepared by** |  | **Date prepared** |  |
| **Relocation Information** [ ]  **Evacuation** [ ]  **Repatriation**  | **Date of relocation** |  |
| **Sending site** |  |
| **Sending/primary physician**Name & phone |  | **Physician orders**Attached/in medical chart | [ ]  Yes  | [ ]  No [ ]  N/A |
| **Receiving site** |  | **Alternate destination**If other than receiving site |  |
| **Arrival to receiving site**Date & time |  | **Received by**Name & designation |  |
| **Emergency contact or** **next of kin** | Notified of departure | [ ]  Yes [ ]  No | **Date & time** |  |
| Notified of arrival | [ ]  Yes [ ]  No | **Date & time** |  |
| **Handover Information** (medical, behavioural, clinical) |
| **Acuity** | Is patient/client/resident **clinically stable** for transfer?  | ☐ Yes ☐ No |
| **Medical diagnosis** | [ ]  None | [ ]  HTN | [ ]  Seizures | [ ]  Stroke/TIA |
| [ ]  Diabetes | [ ]  Mental Health: \_\_\_\_\_\_\_\_\_\_ | [ ]  Other (specify): \_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Cognitive****impairments** | [ ]  None | [ ]  Yes, specify:  |
| **Safety****considerations** | [ ]  None | [ ]  Aggression risk | [ ]  Fall risk | [ ]  Wandering (elopement) |
| **Allergies** | [ ]  None | **Medications** |  | **Food** |  |
| *List on Allergy Alert wristband if available* |
| **Activities of daily living**  | I = IndependentA = Needs some assistanceD = Dependent | **Bathing** |  | **Toileting** |  |
| **Dressing** |  | **Eating** |  |
| **Continence** | **Bladder** | [ ]  Yes  | [ ]  No | **Bowel**  | [ ]  Yes  | [ ]  No |
| **Impairments** | [ ]  None | [ ]  Hard of hearing | [ ]  Deaf | [ ]  Blind | [ ]  Visually impaired |
| **Pre-trip considerations** | [ ]  None | [ ]  Gravol  | [ ]  Ativan | [ ]  Other PRN meds |
| **Language** | Spoken language interpreter required? | [ ]  Yes | [ ]  No | If yes, what language? \_\_\_\_\_\_\_\_\_\_ |
| **Cultural considerations** | Identifies as Indigenous? | [ ]  Yes | [ ]  No | [ ]  Other cultural considerations: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Infection control** | [ ]  Droplet | [ ]  Contact | [ ]  Airborne  |  Details: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Other special considerations** |   |
| **Transfer Considerations** (to be completed when preparing for relocation) |
| **Medical directives** | [ ]  Medical directives (e.g. code status) signed and with the patient/client/resident |
| **Medical or non-medical escort needs** | Is medical or non-medical supervision required for transportation? | [ ]  Yes | [ ]  No |
| If yes, indicate type and number required: | [ ]  Care Aide: \_\_\_\_\_\_ | [ ]  RN: \_\_\_\_\_\_ |
| [ ]  LPN: \_\_\_\_\_\_ | [ ]  Other: \_\_\_\_\_\_ |
| **Spouse or other companions** | Is there anyone who will accompany the patient/resident/client from the same facility? | [ ]  Yes (select below) | [ ]  No |
| [ ]  Spouse, name:  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| [ ]  Companion, name: | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| [ ]  Support/companion animal type: | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Mobility assessment** | [ ]  **Ambulatory** – not dependent on any mobility aids[ ]  **Ambulatory with assistance** – dependent on a mobility aid and/or transfer assistance Mobility aid: [ ]  Cane [ ] Walker [ ]  Wheelchair [ ]  Scooter  Transfer assistance: [ ]  1-person assist [ ] 2-person assist [ ]  Lift, type: \_\_\_\_\_\_\_\_\_\_ [ ]  **Wheelchair bound** – dependent on wheelchair [ ]  powered [ ]  unpowered[ ]  **Stretcher** |
| **Mobility devices** | List the mobility devices that will accompany patient/client/resident to receiving facility:  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Medication** | [ ]  Medication Administration Record (MAR)[ ]  **Send medications for at least 72 hours**Send any and all medications available for patient for transition period[ ]  **Special medications**E.g. IV therapy, chemotherapy, diabetic medications, etc. [ ]  Controlled substances (e.g. opioids) in transit recorded and monitored | [ ]  **Controlled substances in transit** (e.g. opioids) |
| Amount/dose sent:  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Transported by name: | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Signature: | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| [ ]  **Controlled substances received** (e.g. opioids) |
| Amount/dose received: | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Received by name: | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Signature: | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Special transport considerations** | [ ]  Ventilator | [ ]  Suction | [ ]  CPAP | [ ]  Dialysis supplies, date of next treatment: \_\_\_\_\_\_\_\_  |
| [ ]  Oxygen required, L/min: \_\_\_\_\_\_\_\_\_\_\_\_  | [ ]  IV pumps, fluids, supplies ☐ Ostomy supplies  |
| ☐ Specialty mattress | [ ]  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Personal items** | [ ]  Luggage - 1 piece  | [ ]  Hearing aids  | [ ]  Eye glasses  | [ ]  Dentures [ ]  Other: |
| **\*Belongings must remain with patient/client/resident at all times\***Note: if no luggage is available, place all personal items into 1 labelled pillow case |
| **Sustenance provisions** | [ ]  Bagged lunch/snacks | [ ]  Bottled water/juice |
| **Identification and labelling of property** | [ ]  Patient/resident/client has a wristband that indicates: * Name
* Date of birth
* Sending facility
* Receiving facility
 | [ ]  Property has been labelled with an adhesive label or wristband that indicates: * Name
* Date of birth
* Sending facility
* Receiving facility
* Item \_\_\_ of total # \_\_\_\_
 |
| **Other specific considerations** |   |